2880 NW Stewart Parkway #202
Roseburg, OR 97471
(541) 440-9409

To ensure the most efficient process, patients are encouraged to down- load and complete the Request for Services (RFS) form online at dccancerservices.com. The form may then be scanned and forwarded via email to dccancerservices@hotmail.com.

Services Offered:

- Transportation Assistance
- Financial Assistance
- Patient Support Group
- Nutritional Supplements
- Head Coverings (Wigs, Hats, Turbans, Scarves)
- Bras and Prosthesis
- Medical Equipment

Services offered by Douglas County Cancer Services are determined by the following criteria:

- The patient must be a resident of Douglas County.
- The patient must currently be undergoing treatment for a cancer diagnosis.
- The RFS must be completed in its entirety and signed by the patient and medical provider.
- Financial situation of the patient and proof of income may be requested.
- If able, the patient must present themselves to request and receive assistance.
- All services requested must be approved by the patient's medical provider.
- Financial assistance will be determined on an individual basis.

The following services may be provided to patients undergoing cancer treatment when the above criteria are met along with the following:

Transportation Assistance

- A gas card may be provided if the patient travels more than 30 miles (round trip) for medical appointments and/or cancer treatments.
- Other available resources have been researched i.e., Community Cancer Center van for radiology treatments.

Financial Assistance

- Financial aid to assist with living expenses such as utilities, rent or groceries may be available.
- Income information section on the RFS is completed in its entirety.
- A copy of the bill is provided if requesting funds for living expenses such as utility bill, phone bill, etc.
- A new RFS must be completed when requesting additional financial assistance at a later date.

Patient Support Group
A support group is available to all patients, family and/or friends. The support group meets on the third Wednesday of each month at 1:00 pm in the conference room on the 2nd floor at the Community Cancer Center.

Nutritional Supplements
A referral from the Community Cancer Center nutritionist must be provided along with a completed RFS form.

Head Coverings
Wigs, turbans, hats and scarves are provided to cancer patients.

Prosthesis
Bras and prosthesis are provided to breast cancer patients.

Medical Equipment
- Medical equipment may be available for loan to patients undergoing treatment for a cancer diagnosis.
- Specify on RFS what medical equipment is needed.

- ***All lines on the Request for Services form must be completed. If the form is returned incomplete, delays of processing and approval may occur.***

- ***Requests for Services are reviewed and determined by the officers of Douglas County Cancer Services Board of Directors.***

** All services are dependent on available funding **

2880 NW Stewart Parkway
Suite 202
Roseburg, OR 07471
(541) 440-9409

Date Received _____

REQUEST FOR SERVICES

*** All lines must be completed to be processed for consideration ****

Patient Name: _____**DOB:**_____
(Please print)

Address: _____

Phone: _____**Cell Phone:** _____**E-Mail Address:** _____

Employer: _____

Do you have health insurance? Yes___No___ Are you a Veteran? Yes__No__ Number in Household:_____

*** Income information MUST be completed in its entirety for consideration of your request ****

Total Monthly Household Income: Salary/Wages: _____ SS: _____ SSI: _____ VA: _____

Other Income: *(Please explain)* _____

Please tell us how your diagnosis affects your monthly income:

_____

_____

_____

*** Service(s) Requested: (circle all that apply or specify as requested) ****

Wig Turban/Hat Breast Prosthesis Lodging Gas Card Nutritional Supplement

Financial Aid *(rent/utilities)* $_____ Medical Equipment *(specify)*_____

Physician Name: _____**Phone:**_____

Physician Address: _____

_____

Patient Signature ***Date***

** This section to be completed by medical provider only **

Diagnosis: _____

Treatment: Chemotherapy _____ Radiation _____ Both _____ Other _____

Treatment Start Date: _____ **Estimated Length of Treatment:** _____

Medical Provider Name Printed ***Signature*** ***Date***

DCCS Notes Only:

Date:_______________**Action:**____

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_________________________________**Print Name of Volunteer**____

Date:_______________**Action:**____

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